Patient Education in Primary Care

Volume 8 Issue 3 January 2005

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Welcome to our resource for patient education and primary care![1]

WHAT IS IT?

This newsletter provides a mechanism to help meet the challenges of incorporating effective patient education into primary care.

WHO IS IT FOR?

VA Primary Care Teams, Patient Health Education Coordinators and Patient Health Education Committee members, VISN and VAMC decision makers.

Health Literacy Seen as Priority

"Forty million Americans cannot read complex texts at all, and 90 million (almost half of American adults) have difficulty understanding complex texts. Yet a great deal of health information, from insurance forms to advertising, contains complex text. The majority of these adults are native-born English speakers. Literacy levels are lower among the elderly, those who have lower educational levels, those who are poor, minority populations, and groups with limited English proficiency, such as recent immigrants. Even people with strong literacy skills may have trouble obtaining, understanding, and using health information." These statements from the 2004 Institute of Medicine report on health literacy call attention to the scope and importance of the problem.

Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. It includes a number of components beyond reading and writing such as arithmetic skills, listening, and speaking, and it is embedded in cultural and conceptual knowledge.

Published by the VHA Office of Primary & Ambulatory Care and the Employee Education System Patient Education Program

1. This publication may be duplicated.

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A major feature of the report, *Health Literacy: A Prescription to End Confusion*, is a synthesis of research findings on health literacy:

- Adults with limited health literacy have less knowledge of disease management and health-promoting behaviors, report poorer health status, and are less likely to use preventive services.
- There is a higher rate of hospitalization and use of emergency services among patients with limited health literacy.
- Health systems in the United States are often complex and often confusing. Even highly skilled individuals may find the systems too complicated to understand, especially when they vulnerable because of poor health.
- Directions, signs, and official documents including informed consent forms, social services forms, public health information, medical instructions, and health education materials, often use jargon and technical language that make the materials difficult to understand.
- Cultural differences between health care providers and patients may affect perceptions of health, illness, prevention, and health care. Lack of mutual understanding of health, illness and treatments, and risks and benefits has implications for behavior for both providers and consumers; there are also legal implications for providers and health systems.

"Even people with strong literacy skills may have trouble obtaining, understanding, and using health information."

The 1993 National Adult Literacy Survey reported these findings:

- Only 3% of individuals could be considered proficient readers
- 17% had "adequate" health literacy skills but may have problems with informed consent and quantitative skills
- 32% could generally handle everyday reading needs, but lost some abilities when sick
- 27% were marginally literate (below 8th grade)
- The remainder of the population (21%) was functionally illiterate with less than a 5th grade reading level.

The economic impact of low health literacy is significant. Using 1998 figures, the National Academy on an Aging Society estimated that the inability to understand medical directions results in $73 billion of additional health care costs.

The report makes a number of recommendations to address the problem of health literacy, including two recommendations directed to VHA:

- "…funding for health literacy research is urgently needed…Federal health agencies including the Veterans Health Administration and other public and private funding agencies should support multi-disciplinary research on the extent, associations, and consequences of limited health literacy, including studies on health service utilization and expenditures."
- "Health care systems…including the Veterans Health Administration, should develop and support demonstration programs to establish the most effective approaches to reducing the negative effects of limited health literacy. To accomplish this, these organizations should:
  - Engage consumers in the development of health communications and infuse insights gained from them into health messages
  - Explore creative approaches to communicate health information using printed and electronic materials and media in appropriate and clear language. Messages must be appropriately translated and interpreted for diverse audiences.
  - Include cultural and linguistic competency as an essential measure of quality of care."

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Copies of the report have been distributed to the libraries in all VA health care facilities.

In addition, the VHA Consumer Health Library Panel has compiled a directory of health literacy resources to help staff work more effectively with veteran patients. The materials were compiled by Janet Schneider, Patient Education Librarian, at VAMC Tampa. The directory is available at http://vaww.vhaco.va.gov/VALNET/Documents/Health_Literacy_Resources.pdf

The directory includes:

- Health literacy books
- Health literacy bibliographies
- Health literacy web sites
- Development of patient education materials
- Online videos
- Readability formulas
- Free health clip art, graphics and other illustrations.

For further information, contact:

Janet M. Schneider, MA, AHIP, Patient Education Librarian, James A. Haley Veterans' Hospital, Tampa, FL; (813) 972-2000, ext. 6571; Janet.Schneider@med.va.gov

Patient Education/Primary Care Program Notes

Evaluating the Distribution of *Time is Life* Cardiac Patient Education Materials

This 2004 initiative was the first of its kind in VHA—to produce and distribute enough copies of specific patient education materials to all VA health care facilities so that providers could give them to patients. "We wanted to track what happened in the facilities," said Rose Mary Pries, EES Program Director for Patient Education, "so that we could learn what worked and what didn't. That will help everyone when future system-wide initiatives are planned."

The *Time is Life for Heart Attack* patient education materials were designed to help veterans recognize the warning signs of a heart attack and develop a personal heart attack survival plan so that they would seek immediate treatment if symptoms occurred. The educational products included brochures and wallet cards in both English and Spanish versions, a wall poster, a heart attack survival/risk assessment action plan, and a video, *Time is Life: Combat Heart Attack and Survive*. Over 1,000,000 brochures were distributed to the Ambulatory Care Manager at each VHA facility. Veterans would receive the patient education materials at VA clinic visits and discuss their survival action plans with their providers during the visit.

Prior to the distribution of the materials, a number of methods were used to alert the field to the initiative's goals, the purposes of the patient education materials, and suggestions for local dissemination and utilization strategies. These communication methods included:

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- VHA Information Letter 10-2004-003 from the Under Secretary for Health describing the initiative, the materials, and the dissemination plans
- A national conference call conducted by the EES Program Director for Patient Education that included patient educators, primary care clinical managers, diabetic educators, and other providers of high risk patients
- A public affairs conference call conducted by the EES Program Director for Patient Education
- A memo from the EES Project Manager for the initiative addressed to the "EES Facility Education Coordinator" which accompanied the video and DVD and granted permission to duplicate them
- A memo from the Chief Consultant for the Acute and Specialty Care Strategic Health Group sent to the Ambulatory Care/Primary Care Clinic Managers inviting them to participate in this initiative.

Evaluation Project

The goals of the evaluation project were to examine the:

- dissemination of the materials to the field
- extent to which clinical providers were informed that the materials were available
- methods used to inform clinical providers about the materials
- lessons learned from this initiative that would enhance the system-wide distribution of patient education materials for other national initiatives.

In July 2004, follow-up surveys were sent via mail or e-mail to three groups involved in the initiative:

- Primary Care Clinical Managers or Ambulatory Care Managers at each VHA facility (N=172)
- Patient Health Educators (N=104)
- A multidisciplinary group of clinicians who attended the "Time is Life" Conference in February 2004 in Washington, DC (N=271).

Respondents had the option to respond via mail or e-mail or to complete the survey anonymously on the Cardiology Program Office web site. 274 people responded to the survey: 31 (18%) of the PCCMs; 94 (88%) of PHEs; and 149 (55%) of the conference attendees. 218 (80%) respondents stated that they had received the patient education materials.

Informing Providers

A total of 195 respondents (89% of the 218 who reported receiving the materials) stated that they had informed providers that the patient education materials were available in their facility. The method most commonly used to communicate with providers was reporting at staff meetings. Respondents either distributed the patient education materials during staff meetings or informed providers during the meetings, usually in combination with e-mail messages and verbal communication. Slightly more than 50% of all respondents described combination methods to inform providers about this initiative.

Another commonly reported method of communication was through e-mail messages. A small minority of respondents stated that they used this as the only method of informing providers. Others used an e-mail message in combination with meetings, distribution of materials either directly to providers or to the clinic areas, and educational sessions (which included grand rounds, in-service sessions and conferences). Approximately 5% of the respondents stated that their facility had used an informatics method to inform providers. In some cases, these facilities developed a clinical reminder, designed a template in CPRS or used a website link to educate and inform their providers about this initiative.

Twenty-one respondents stated that they had not informed providers. The most common response was that someone else (the cardiology department, education office, administration, or nursing) took care of informing providers. These respondents did not have any information on how the providers were informed. Six respondents stated that they were not given enough time to address this, either because of their clinical duties or because the materials had been delayed. An additional eight respondents stated either that the patient education materials ended up somewhere else, were not sent to the respondent, or the respondent is not responsible for primary care education.

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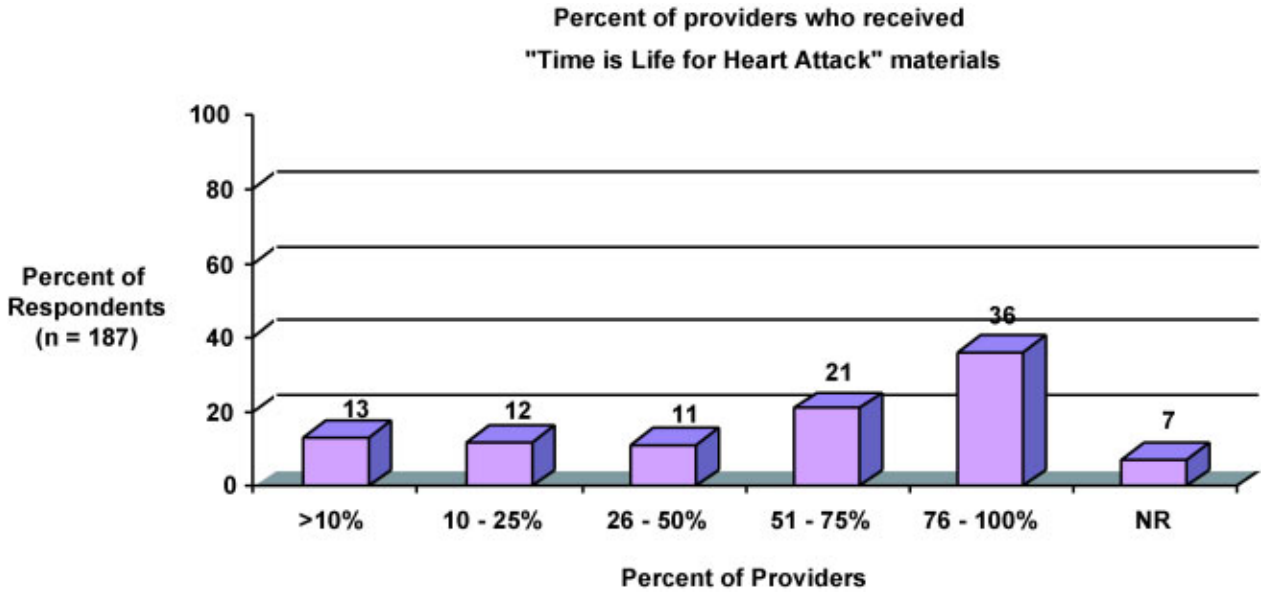
Distributing Materials to Providers and Patients

A total of 187 respondents stated that they had distributed the patient education materials to providers and/or patients. When asked to estimate the percent of providers who had received the materials, more than half of the respondents (57%) estimated that most providers had received the patient education materials.

Distribution of materials was done during one-on-one encounters with providers or to groups of providers at a time (such as during staff meetings). Respondents also stated that they distributed the patient education materials to outpatient clinics, cardiology, primary care teams, CBOCs, and inpatient units. A few respondents stated that they had displayed posters, brochures and videos in patient waiting areas and patient resource centers. Others stated that they had used an employee newsletter or bulletin board to display the materials for providers.

Almost three quarters of the respondents stated that their CBOCs had been informed, using a variety of methods. Eleven respondents stated that they didn't know how CBOCs were informed. Of the respondents who answered that they did inform the CBOCs that the materials were available, a little over half stated that CBOCs had disseminated the materials to their patients and/or providers whereas a little over 40% stated that they didn't know if the materials were disseminated.

Almost 50% of those who responded to this question stated that there had been no collaboration in the dissemination of the patient education materials. When the respondent stated that there had been collaboration, the majority of the responses involved collaborations between the *Time is Life* coordinator, the ACS Implementation team and/or an interdisciplinary team usually collaborating with a patient education committee.



Feedback from Providers

Most of the respondents (125) stated that they had not received any provider feedback regarding the patient education materials. Sixty-six respondents stated that providers had given them feedback. The majority of the feedback regarding the design and content of the materials was positive. Providers also commented positively on the video, which they considered informative and at an appropriate literacy level for their veteran population. Wallet cards also seemed to be popular among the veterans.

A smaller percentage of comments were negative, mostly voicing concerns that veterans will still drive long distances to a VA facility to avoid paying for 911 services. A few thought that this was just one more thing they were expected to do. Others had negative comments about the design of the materials. Some said "getting veterans to agree to a contract may be difficult."

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Barriers to Dissemination

One-third of respondents stated that there were no barriers associated with the dissemination of the patient education materials. Approximately the same number of respondents cited barriers to the timeliness of getting this initiative off the ground in their facility, including:

- confusion as to who was responsible for the "roll-out" of the initiative and confusion as to who received the materials initially
- having to use local funds to make copies of the materials because the orders were not arriving on a timely basis
- lack of facility readiness to implement the initiative (lack of audiovisual equipment to show the video, lack of frames for posters, storage space for materials)
- inadequate time to discuss these materials with patients during a patient visit
- a sense of guideline information overload
- a sense that there are too many competing priorities which would prevent sustaining the initiative
- organizational barriers (lack of centralization, communication, collaboration with patient education services, and/or a plan within the facility)
- lack of guidance as to which areas in the facility to target or what to do with the materials
- limited resources to address the barriers when they did occur and little follow-through within the facility.

Conclusions

"It's clear from the evaluation findings that most respondents thought the materials were well done and that the content was important," said Pries. "However, there were some problems with the distribution of the materials that caused delays," she added. "A primary barrier to dissemination was the difficulty identifying appropriate personnel in primary and ambulatory care to receive the boxes of pamphlets and cards. More direction, guidance, and follow-up would have been helpful."

"We paid attention to these concerns and modified the distribution protocols for centrally-produced patient education print materials as a result of this evaluation," said Pries. "Now materials are sent directly to each facility's patient education contact person, from a list maintained by the EES Patient Education Program Office. Based on the results of this study of the distribution of cardiac education materials, the VACO Office of Primary/Ambulatory Care and the Advanced Clinic Access Program mandated this recommended distribution for patient education print materials and two patient education video productions. These distributions were very successful and resulted in many fewer problems," she noted.

"We also need to continue to inform all field-based staff involved in an initiative—EES VISN Teams, education contacts, patient education contact persons, clinicians, librarians, etc. before, during and following a planned distribution via hotlines, conference calls and e-mail messages," she said. "In the future, we'll prepare a user's guide for each product that will suggest strategies for forming the needed teams to plan and implement educational activities and facilitate the local distribution of materials within the facility, to its CBOCs, and to veterans," she said.

A national follow-up survey of 5000 patients is being planned to determine what actions they took as a result of receiving the *Time is Life for Heart Attack* materials.

For further information contact:

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Patient Education Resources

Health Calendar for Veterans

The patient education committee at the Bay Pines, FL VAMC wanted to help improve the facility's outcomes on performance measures related to patient education and get patients more involved in their health care, so they searched for a way to achieve these goals. In 2003, they created a wall calendar for veterans tied directly to the health concerns of the VHA performance measures. Why a calendar? Diana Akins, co-chair of the committee, explains: "It's a product that everyone needs. Patients can take it home and use it every day of the year. It can contain a lot of useful information presented in a non-threatening approach, and it's bright and colorful."

The committee examined performance measure scores and chose those with the greatest opportunity for improvement or those considered "hot topics" for 2004. They developed a list of major and secondary topics as well as a health tip for each month. The list was reviewed by members of the Committee, the Quality Systems staff, and the Chief of Staff. The monthly topics for 2004 were:

- doctor-patient communication
- weight management/nutrition, physical activity/exercise
- immunizations
- screening (colorectal cancer, skin cancer, prostate cancer)
- substance abuse (alcohol and tobacco use)
- women's health issues (breast cancer, pap smears)
- Hepatitis C
- emerging infections (pneumonia, vaccinations)
- coronary issues (heart attack, heart failure, stroke, and hypertension)
- diabetes
- mental health issues.

"We wanted the layout to contain maximum information but be easy to read. We wanted the terminology to be the same as that used in the patient satisfaction surveys, and we wanted the full-color animated graphics to show diversity, be age-appropriate, and reflect the concept of 'veterans'," Akins said. "We found a vendor who was willing to work with us on personalizing our product and designing it to meet our exact specifications," she added. Prototypes were examined and shared with patients and staff members until all were satisfied.

The inside back cover contained an area for recording personal health information such as blood pressure, cholesterol, weight, fecal occult blood test, colonoscopy, sigmoidoscopy, tetanus shot, pneumococcal vaccination, allergies, and medications. That page also included space for important contact information. The back paged contained the toll free telephone numbers and web site addresses of national health agencies.

The initial 2004 calendar was distributed by a variety of clinical staff at Bay Pines, and manual entries were made in CPRS as patient education notes. It quickly became apparent that a clinical reminder was needed, so one was developed for the distribution of the 2005 calendar. At Bay Pines, the 2005 calendars are distributed by nurses either in ambulatory care or as part of the discharge package on inpatient units. "Staff tell us they're proud to have such a resource to give patients, that the calendars are colorful, relevant, and easy to read, and that patients really like the calendar," said Akins. "Many clinicians also hang the calendars in their offices so they can go over the content and health tips with patients," she added.

The 2004 calendar was shared with the other facilities in VISN 8 by the Bay Pines Medical Center Director, Mr. Smith Jenkins. There was enough interest for a group purchase within VISN 8. Response to the calendar

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was very positive, and a need for a Spanish version was indicated. The vendor worked closely with the San Juan VAMC to convert the English text to Spanish. The 2005 calendar was adopted as a formal VISN 8 project, and the monthly topics were based on VISN-level performance measure scores.

Information about the calendar was widely shared within VHA. As a result, twenty-one other VA facilities are using the calendar with their patients. The vendor tailors front and back cover information for each facility and/or VISN. Almost 500,000 copies of the 2005 calendar have been ordered.

"We surveyed patients and staff for their reactions to the 2004 calendar and incorporated their suggestions into the 2005 version," Akins said. "For example, patients wanted larger print, reminders of the dates when VA clinics would be closed, more information on VA benefits, and information on VA/VHA programs (e.g. MyHealth*e*Vet and *Time is Life for Heart Attack*)."

Feedback from patients and staff in VISN 8 and at other VA facilities using the calendar is guiding development of the 2006 edition. The goal is to have it ready for an earlier distribution, preferably in October. "Work is already underway," Akins said. "The topics and cover have already been determined. Next year's calendar will use photographs instead of animated graphics," she added.

Readers interested in obtaining information about the format, personalization options, and costs of the 2006 calendar can check the vendor's website at http://www.personalbest.com/clientproof/2005VA_anim_Cal.pdf.

For further information contact:

Diana Akins, MA, Chief, Library Service, VA Medical Center, Bay Pines, FL; (727) 395-9366; Diana.Akins@med.va.gov

Teach Tip

Helping Patients with Low Literacy Skills

When you're talking with a patient who has limited literacy skills, consider these strategies to help the patient follow the conversation more easily:

- Choose only one or two objectives per interaction; make explicit what behaviors are expected
- Focus on behaviors and skills, not discussion of concepts
- Present the context first, then give new information
- Break up complex instructions into smaller parts (3 to 5 items at a time at most)
- Make the discussion as interactive as possible so you can determine if the patient understands what you're saying.

When you provide printed materials to supplement your verbal instructions, keep these factors in mind:

Poor Readers	Poor Readers Need
Read slowly	Short sentences
Have a small vocabulary (including punctuation)	Visuals to support text, or videos or audiotapes
Miss the context	Examples
Don't know categories (e.g. fluids)	Specifics
Don't know abbreviations	Words spelled out
Have difficulty decoding ALL CAPS	Upper and lower case; bold or underline for emphasis

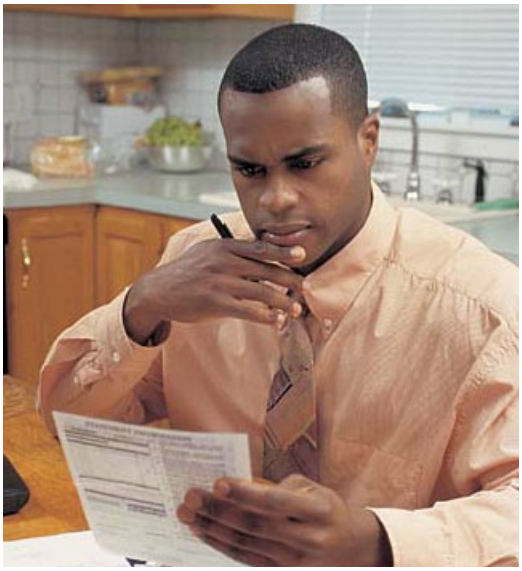
Critique the printed materials you use for the following features:

- a reading level no higher than sixth grade
- short, common words instead of medical terms-e.g. pill instead of medication, eat instead of consume
- active voice
- short paragraphs that present one important issue
- font size between 12 and 14 points; easy-to-read type style
- right margin jagged, not justified, to help readers distinguish one line from the next
- illustrations (appropriate and meaningful) placed next to the relevant text
- interactive style that allows for reader involvement
- new words defined clearly
- each idea clear and logically sequenced
- limited number of concepts per piece
- text highlights and summarizes important points
- headers guide the reader through the content
- layout balances white space with words and illustrations.

How do we know patient education works?

Designing a Patient Satisfaction Instrument for Low-literacy Populations

This project was undertaken to develop and test an illustrated version of the VHA Ambulatory Care Customer Satisfaction Survey in order to make it easier for patients with low-literacy skills to use it. The study was conducted at the Philadelphia VA medical center and at a nearby academic medical center; 438 patients participated in the process.



Investigators used a combination of focus groups and individual interviews to determine patient interpretations of drawings intended to portray the meaning of the 62 items on the instrument. Using an iterative process over a 1-year period, the drawings were revised based on patients' and investigators' comments, then tested again, and revised as needed.

The final booklet contained 22 pictures rated as "understood," 39 pictures rated as "partially understood," and 2 pictures rated as "not understood." The authors present a thoughtful discussion of the lessons learned from the project, along with recommendations for developing illustrated versions of text-based instruments.

Weiner J, Aguirre A, Ravenell K, et al. (2004) Designing an illustrated patient satisfaction instrument for low-literacy populations. The American Journal of Managed Care, 10(11):853-60.

Influence of Patient Literacy on the Effectiveness of a Diabetes Management Program

This randomized controlled trial, conducted at Vanderbilt University Medical Center, was designed to test the influence of patient literacy on the effectiveness of a primary care-based diabetes management program.

Participants included 217 adult patients with type 2 diabetes and poor glycemic control. Patients in the intervention group received individual communications designed to enhance understanding among patients with low literacy along with intensive disease management assistance from a multidisciplinary team. Patients in the control group received an initial management session and usual care.

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During analysis, findings were stratified by patient literacy status. At 12-month follow-up, low literacy intervention patients were significantly more likely than control patients to achieve glycemic control. Patients with higher literacy skills had higher odds of achieving control regardless of intervention status.

The authors conclude that literacy may be an important criterion for predicting who will benefit from a disease management program, especially if the program addresses the needs of patients with low literacy skills.

Rothman RL, DeWalt DA, Malone R, et al. (2004) Influence of patient literacy on the effectiveness of a primary care-based diabetes disease management program. JAMA, 292(14):1711-6.

Patient-centered Care and the Provision of Preventive Services

This study, conducted at the Iowa City VAMC, was designed to examine the association between delivery of patient-centered care and preventive services. Investigators analyzed all VA facility scores for eight dimensions of patient-centered care on the 1999 VHA Ambulatory Care Veterans Satisfaction Survey against the provision of twelve US Preventive Services Task Force recommended interventions.

Delivery of preventive services ranged from an overall mean of 90% compliance for influenza vaccinations to 18% for screening for seat belt use. Mean overall scores for patient-centered care ranged from >90% for continuity of care and courtesy to <70% for patient education.

The factors most strongly correlated with better delivery of preventive services included: how often patients were able to discuss their concerns with their provider; the percentage of visits at which patients saw their usual provider; and the percentage of patients receiving >90% of their care from a VA facility.

Flach SD, McCoy KD, Vaughn TE, et al. (2004) Does patient-centered care improve provision of preventive services? Journal of General Internal Medicine, 19(10):1019-26.

Cholesterol-lowering Effect of the Food for Heart Nutrition Education Program

The purpose of this prospective, randomized trial conducted at the Thomas Jefferson University Hospital in Philadelphia was to determine the effectiveness of the Food for Heart nutrition program in outpatients with elevated cholesterol levels. Participants included 175 hypercholesterolemic adults not taking cholesterol-lowering medications. Intervention patients received four monthly dietary counseling visits using the Food for Heart program.

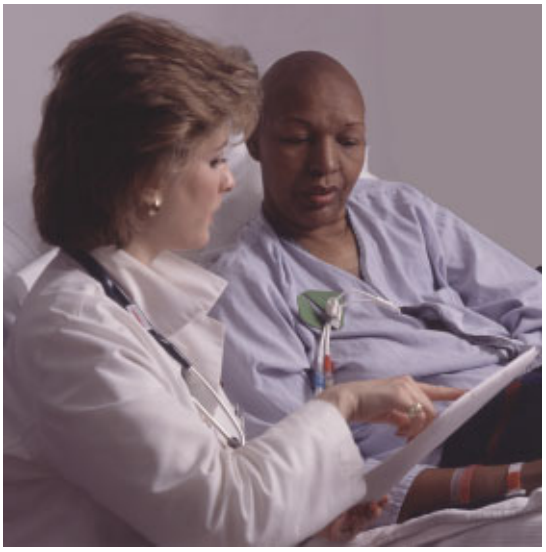
Intervention patients showed significantly lower total and low-density lipoprotein cholesterol. There was no significant change in high-density lipoprotein cholesterol. Intervention patients lost a small but statistically significant amount of weight and decreased their Dietary Risk Assessment scores.

The authors conclude that the Food for Heart program was successful in lowering dietary risk for coronary heart disease among patients who received the program.

Cheng C, Graziani C, Diamond JJ. (2004) Cholesterol-lowering effect of the Food for Heart nutrition education program. Journal of the American Dietetics Association, 104(12):1868-72.

Effectiveness of a Patient Self-management Approach to Chronic Inflammatory Bowel Disease

This multi-center randomized controlled trial was conducted in the outpatient departments of 19 hospitals in and near Manchester, England. Ten sites served as controls and nine as intervention sites. Participants included 700 patients with established inflammatory bowel disease. The intervention consisted of helping patients negotiate an individualized self-management plan emphasizing patient choice, along with written information.



At 1-year follow-up, self-managing patients had made significantly fewer hospital visits without increasing the number of primary care visits compared to control patients. Intervention patients also reported significantly higher levels of confidence in being able to cope with their condition immediately following the intervention. There was no difference in levels of patient satisfaction between the two groups.

Kennedy AP, Nelson E, Reeves D, et al. (2004) A randomized controlled trial to assess the effectiveness and cost of a patient orientated self management approach to chronic inflammatory bowel disease. Gut, 53(11):1639-45.

Performance Improvement Training

Every quarter, *Patient Education in Primary Care* will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit, choose one of the following two options:

Read the entire January 2005 newsletter and provide brief answers to the questions below. Turn these in to your supervisor along with a copy of the newsletter

OR

Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the newsletter and discuss the questions below. Turn in a master list of participants along with a copy of the newsletter.

Questions:

1. What strategies are currently used at your facility to identify and help patients with limited health literacy? What can you do to help?
2. How might health calendars be used with veterans in your facility? What suggestions would you make to enhance these efforts? Are there other products that could be developed for veterans to address priority health concerns?
3. To what extent are patient self-management programs used in your facility to help patients with chronic diseases? What suggestions would you make to enhance these efforts?

DO YOU HAVE ANY SUCCESSFUL PATIENT EDUCATION STRATEGIES THAT YOU WOULD LIKE TO SHARE WITH US?

Contact any of the following with your input:

Barbara Hebert Snyder
(216) 691-9393
snyderbarbara@ameritech.net

René Haas
(562) 826-8000 ext. 2322
rene.haas@med.va.gov

Charlene Stokamer
(212) 686-7500 ext. 4218
charlene.stokamer@med.va.gov

Coming in APRIL:

Personal Health Journals for Patients

PATIENT HEALTH EDUCATION IN PRIMARY CARE TASK FORCE:

This newsletter is transmitted electronically to VHA staff. To add colleagues to the distribution list, contact your local patient education coordinator or committee chairperson.

Employee Education System

Office of Primary and Ambulatory Care

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES